CGRP Antagonists

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval (at least one of the following criteria must be met):

- ❑ Patient is 18 years or older.
- ❑ Diagnosis of Chronic Migraine or Episodic Migraine per established criteria from International Headache Guidelines. (see website https://www.ihs-headache.org/ichd-guidelines for guidelines)
- ❑ Diagnosis of episodic cluster headache, for Emgality only.

Additional Criteria for Injectable Migraine Prophylaxis:

- ❑ Trial and failure of one agent from 3 of the 4 following drug classes: *(Trial must be for a minimum of two months)*

  Botulinum toxin A: _____ Dates of use: _____ Details of Failure: _____

  Beta-blocker: _____ Dates of use: _____ Details of Failure: _____

  Tricyclic Antidepressant: _____ Dates of use: _____ Details of Failure: _____

  Anti-epileptic: _____ Dates of use: _____ Details of Failure: _____

Additional Criteria for Oral Migraine Abortive Treatment:

- ❑ Trial and failure or contraindication to 2 triptans:

  Triptan: _____ Dates of use: _____ Details of Failure: _____

  Triptan: _____ Dates of use: _____ Details of Failure: _____

Additional Criterion for Episodic Cluster Headache Treatment:

- ❑ Trial and failure of Verapamil. Details: _____ Chart Note Page #: _____

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Trial and failure of preferred CGRP, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for non-preferred product. Details: _____ Chart Note Page #: _____

Quantity Limits: Nurtec (rimegepant): Max of 15 tablets per 30 days. **Ubrelvy** (ubrogepant): Max of 16 tablets per 30 days.

Re-authorization Criteria: Updated letter of medical necessity or updated chart notes demonstrating positive clinical response with improvement in headache frequency (prophylaxis) or severity (abortive treatment).

Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Note:

- ❖ Concomitant use of other preventive antimigraine and abortive migraine CGRP therapy is acceptable.
- ❖ Concomitant use of botulinum toxin A with preventive CGRP is an off-label use.

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date